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Vol. XXIII JUNE, 1953 No. 6

SCOPE OF HEALTH INSTRUCTION, GRADES 1 TO 12*

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Health instruction is in the curriculum, but its status has remained ill-defined. Educators agree that health is a desirable objective, and that instruction should be directed toward attaining better health. Other points, however, are not so clear in developing the scope of health instruction. It is the purpose of this paper to synthesize present-day theories and practices related to some of these problems.

Procedure

The current theories and practices presented were derived from two major sources: first, professional books, journals, and research reports were reviewed; and second, a brief questionnaire of how to determine health needs and select problems was formulated and sent to Directors of Curriculum Construction in 75 city schools. The cities selected were those considered large and progressive enough to employ services of curriculum specialists and, therefore, to submit concrete information; and those located according to wide geographic distribution throughout the United States. Completed questionnaires were returned by 39 cities. This return of 52 per cent of the requests for information is a small sample, but is considered fairly representative since 15 cities are in the south and southeast, nine in the west and northwest, and 15 in the central and northeastern sections of the country.

Discussion

What is health instruction? Among the several problems and issues facing us today is that of understanding what health instruction really is. An overview of present practice in programs of health instruction reveals conformity with theories evolved during the last century, and outmoded a number of years ago. There are those people for whom health instruction means simply instruction in anatomy and physiology; those who believe that a knowledge of

* Presented before the American *School Health Association*, October 20, 1952.

health facts automatically initiates interest in healthful living; those who offer disease instruction, rather than health instruction as a means of being healthy; those who believe that health instruction is synonymous with instruction in physical activities; and those who assume that routine, mass rendering of free health services provides adequate health instruction.

The newer concepts of health learning involve consideration of what the individual knows, how he feels, and what he does in his home, at school, or in his community. Health instruction today should deal primarily with using direct plans and teaching procedures to obtain desirable health outcomes (18).

The best programs of health instruction are based upon the specific health needs and problems of pupils and of the community, and they arise nowhere else but in the school and community. If health instruction is adequate, its program must be adapted, not adopted. It is possible to suggest general areas of need, and to review procedures which have been useful in other situations; however, these reviews should be considered only as provocative ideas for determining the immediate needs and techniques.

How are health needs determined? It is necessary to know which health problems need attention before the actual scope of the instructional program can be determined. Leaders in health education suggest six important procedures for determining particular health needs:

First, questionnaires, inventories, and interviews are used extensively in determining pupils' health interests. Two significant, recent studies are mentioned. The Denver Study (3) of health interests and needs of 3,600 Denver public school pupils indicated predominant concern, increasing with age, about personal appearance and social adjustment and acceptability. Lantagne's (9) inventory of the health interests of 10,000 secondary school students in ten states revealed that more than 50 per cent of the students are interested in such specific health problems as sex instruction, juvenile delinquency, causes of suicide, cancer, habit-forming substances, problems of tooth decay, causes of mental illness, care of eyes, accidents, and preparation for marriage.

Second, studies of personal health practices of children give material of value in planning to meet health instruction needs. A survey of the health habits of 3,500 boys and girls, reported by O'Neill and McCormick (14), showed that children's status in health habits is markedly deficient, and either remains fairly con-

stant or shows an increase in poor health habits with increase in age. General Mills, Inc. (6) reported a survey of the eating habits of nearly 60,000 school children in 39 states, which showed that diets are poor and tend to become poorer as children grow older. It was indicated from a study of the health practices, knowledge, attitudes and interests of 10,000 senior high school pupils in Massachusetts (15) that health practices, knowledge, and attitude scores remain fairly constant, and areas of greatest interest relate to personal health, nutrition, mental health, oral hygiene, use of tobacco, sex education, and cancer.

A third important procedure in finding health needs is review of health histories and medical records of each child. Height and weight records, screening tests, and special otological or orthopedic records should be considered also. Comparison of local vital data with state and national trends may help to evaluate progress and indicate needs. A comprehensive, statistical presentation of the social, economic, and health conditions and services important to the nation's children and their families was published at the request of the Midcentury White House Conference on Children and Youth (12). The National Safety Council (13) publishes, annually, the facts and problems of accidents. The Public Health Service of the Federal Security Agency publishes monthly *Public Health Reports* (4) which is a source of morbidity and mortality data for the nation.

Fourth, a study of the health needs and resources of environmental factors in the total plant is valuable in identifying learning opportunities. Excellent check lists and survey forms for the appraisal of school environments have been prepared by departments of health and education. Sturkie (17) reported a comprehensive survey and study of the environments of 20 schools in a fairly typical southeastern city, where he found such conditions as 10 per cent of the pupils provided with adequate play space; 25 per cent with recommended toilet equipment; 4 per cent with recommended adjustable seating; and 9 per cent with buildings where dust settler was used in sweeping. The implications for the health instruction of pupils, school personnel and parents, alike, are obvious.

Fifth, a study of the home and family background, with particular reference to existing or needed parent cooperation in solving health problems, provides a further basis for determining health needs. Parents and community health resource persons should be represented on committees which plan, conduct studies, and revise

health curriculums. Community participation is the surest way to secure community cooperation in solving health problems.

The sixth and last suggestion for determining health needs is the use of expert opinions and review of current, authoritative materials in the related health fields. Common health needs of all children are studied and reported by experts, and the developmental characteristics of children at various age levels are available. It would be impossible to mention the many leaders and significant contributions in health and allied fields. Byrd (1) publishes an annual summary of leading health problems and developments as represented by articles on health which have appeared in allied scientific journals. His assumption is that health problems discussed in the professional literature are not trivial or insignificant, and should have value for those who determine the scope of health in the curriculum.

With these six recommended procedures in mind, it was desired to know how health needs are determined by the selected city schools. Approximately one-half of the 39 cities reporting stated that organized health research or field studies among students or other groups had revealed the needs, interests, and problems upon which their instructional programs were planned. Some of these research studies have been published and were mentioned earlier. Many cities reported, however, that they are using research when content selection is to be based upon individual teachers' judgments, opinions of experts, other courses of study, or health textbooks. A few cities indicated that use of individual school surveys, physical and dental examination results, community surveys, continuous observation, and joint planning with health organizations were helpful guides in determining health needs.

The 39 cities of the survey offered the following approaches to improve the present methods of determining health needs and developing programs of health instruction: colleges should require for graduation and state departments of education for certification, more health education for every teacher; more teachers, community health agencies, local medical personnel, students, and parents should participate in planning; all teachers and the general public should be kept informed of what is being done for health; regular in-service education, workshops and refresher courses should be provided through summer schools and extension divisions; present guides should be evaluated and revised regularly in order to incorporate necessary changes in scope and emphasis; teacher and pupil research studies and surveys should be conducted to determine

needs and follow-up findings; time should be designated for planning and instructing in health; and functional school health committees with broad representation should be formed.

How are problem areas selected? When health and curriculum construction committees organize indicated health needs around problem areas, the categories should be ones which have definite meaning and importance to them and to the pupils for which they are designed. Major health problems needing emphasis should be agreed upon, and tentative plans proposed for their solution. Broad provisions should be made to insure variety, continuity, and increasingly complex health learnings throughout grades one to twelve. Content of health instruction should be guided by the selection of proposed experiences, appropriate to the child's maturity, which meet the child's interests and needs, and which are possible and realistic. Leary (10) found that there was marked similarity in topics found among courses of study and teaching guides in health. This uniformity, according to Strang (16), may be ascribed to wide acceptance of the common needs of children, and to the tendency of school systems to copy the content of textbooks and other courses of study.

Leaders, and most teachers, have their own ideas concerning the classification of materials for teaching purposes. California (2) and Colorado (3) recommend emphases for ninth and tenth grades, and recommend other areas for grades eleven and twelve, in order to meet the increasing maturity of students. Oregon's plan for secondary schools includes the major areas which were identified by Hoyman (7). It is generally agreed that the selection of problem areas in elementary schools should be made according to the common basic health needs of all children. Emphasis is placed upon the child, and upon his gradually assuming greater responsibility in directing his own health habits.

It is interesting to compare these approved procedures for selecting problem areas in health instruction with the practices reported by the selected city schools surveyed. Twenty-eight per cent, or 11 cities, believe that acceptance of state guides, where the scope is determined on a state-wide basis, is the best procedure. Since eight of these 11 cities are located in the south and southeast, it appears that the predominantly rural areas and small towns in this section, where competent local direction in curriculum construction is not feasible, are responsible for wide use of state guides to determine problem areas. Thirty-eight per cent, or 15 cities, indicate that they use a state course of study which is modified to

fit local conditions. Sixty-two per cent, or 24 cities, indicated that state guides are most useful to locally determined instructional programs as a resource and a supplement only.

Sixty-two per cent, or 24 cities, reported that it is not practical for individual teachers to determine the scope of health instruction. Reasons given for this impracticality were that average individual teachers are not qualified, the group method is more effective in educational planning, and continuity cannot be accomplished where teachers plan individually. The 38 per cent, or 15 cities, which consider that it is practical for individual teachers to determine the scope of health instruction point out the following suggested procedures: teachers should work on various grade level and special area committees; individual teachers should be provided with considerable guidance; and there should be, always, a basic framework of the over-all program within which teachers may select and adapt units which are articulated and provide continuity of instruction.

Ninety-three per cent, or 36, of the cities indicate that their health instruction programs provide for articulation and continuity from grade level to grade level, without unnecessary duplications or undesirable gaps. The following suggestions are given for accomplishing this task: use state guides planned for total programs in health for grades one to 12; provide adequate supervision and in-service education through such procedures as group and individual conferences, circulation of special teaching materials and outlines, and representative central health committee planning; grade visual aids and other supplementary material; agree on various emphases and approaches in the areas of health instruction for different grade levels; adopt a series of health texts which are graded; and review the health course of study, evaluate it, and revise it continuously. It seemed to be rather generally stated that the only adequate approach to articulation and continuity of instruction in health is through well-laid plans which are carried out by well-trained personnel.

The 39 cities reported in the present survey were asked to indicate the most neglected areas of health instruction in their programs, and to list the main topics which should be included in a modern health education curriculum. By far the most numerous suggestions for needed additions, made by 45 per cent, or 13 cities, refer to problems concerning mental and emotional health. Insufficient emphasis is being given to sex education and to personal health, according to 21 per cent, or six programs reported. Home and family living is listed as a neglected area in 11 per cent, or

three cities. Civil defense, first aid, and driver education are mentioned as needs in at least two cities.

Main topics of health instruction which 25 per cent, or seven cities, listed for inclusion in a modern health education curriculum are as follows: personal hygiene, mental and emotional health, sex education, protection from infection and disease, food and nutrition, structure and function of the body, care of teeth and special sense organs, home and family living, safety, and personal appearance.

How is health instruction done? The teacher's job, then, is to study, plan, and guide toward healthier living for all pupils. Health teaching and health guidance must parallel each other, and must be based upon scientifically accurate information. The job of health instruction is not a simple one.

It is assumed that health behavior is motivated, and that its motivation can be influenced. Galdston (5) states that actions and behavior are directed by needs or by desires, many of which stem from the emotional, not the intellectual, nature. These motivations are often multiple, and may be conflicting. Therefore, the job of health education is not merely to teach the facts of hygienic living, but to persuade people to apply these facts. Kubie (8) reminds us that since we are all human, we are not immune to strange conglomerations of fact, fantasy, and fads, however, we rationalize them in scientific terms.

Margaret Mead (11) believes that attitudes toward health throughout the major portion of the United States stem from a Puritan base. The theory behind this point of view is that all good health behaviors are those for which an individual will be rewarded in one way or another; for example, a child with a lolly-pop, or an adult by a long and fruitful life. Dr. Mead maintains that within such a context, no matter how many gold stars a child gets after each good habit, or how successful the health campaign, the pupil also learns that these are virtuous acts which could never be performed simply for their own enjoyment. We are entrenched with the Puritan tradition of deferred rewards for a life of trials, and the contrast between good and good for you, and between fun and duty, underlies our attitudes, and shapes the way in which health instruction is accepted or rejected.

Summary

Review of current theories and practices in selected large cities indicates needed improvements which may be even more serious in areas where educational support is weak and systematic curriculum

planning receives little consideration. In conclusion, it would appear that immediate attention should be directed toward the following in developing the scope of health instruction:

1. Inform teachers, health personnel, and the general public of newer concepts in the scope of health instruction.
2. Improve inadequacies of school environments.
3. Conduct and promote original, organized, health research among students, teachers, and community in order to know health needs.
4. Establish college graduation requirements in basic health and hygiene for all students.
5. Upgrade certification requirements of all teachers by providing for health education.
6. Provide direction and regular school time for health planning and instructing.
7. Establish functional health committees with broad representation in every school.
8. Evaluate and revise the health curriculum regularly.
9. Develop comprehensive state health teaching guides with suggestions for local use.
10. Develop local health teaching, based upon current local needs, that will provide for articulation and continuity of health instruction.

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Health Education Workshops in Pennsylvania.—The Inter-Agency Planning Committee representing the Pennsylvania State Departments of Health, Welfare and Public Instruction, the Pennsylvania Tuberculosis and Health Society and the Medical Society of the State of Pennsylvania, cooperating with six colleges and universities, will sponsor six Community-School Health Education Workshops this summer as follows:

The Pennsylvania State College	June 9—June 26
Slippery Rock State Teachers College	June 29—July-17
West Chester State Teachers College	June 29—July 17
Temple University	June 29—July 17
University of Pittsburgh	June 29—July 17
Lehigh University	June 16—July 3

The purpose of these workshops is to help develop a sound health education program with emphasis on home-school community relationships.

To insure a better rounded approach, participants for each workshop will be selected from varied backgrounds. They may be: teachers, nurses, school administrators, dental hygienists, guidance workers, parents, voluntary community health organization staff members, health department workers, board of health representatives, etc.

Information on scholarships for the Workshops and other essential details may be obtained from: Dr. Elmer B. Cottrell, Chairman, Chief, Health and Physical Education, Pennsylvania Department of Public Instruction, Education Building, Harrisburg, Pennsylvania.

GETTING THE FAMILY READY FOR THE CHILD'S FIRST DAY AT SCHOOL—AN EXPERIENCE IN SEDGWICK COUNTY, KANSAS

FRANKLIN K. BROUGH, M.P. H. AND
M. LEON BAUMAN, M.D., M.P.H.
Director of Public Health Education and Director of Public Health, Wichita-Sedgwick County Department of Public Health, Wichita, Kansas

This paper describes a program of pre-school classes for parents and pre-school age children that has been received with enthusiasm in Sedgwick County, Kansas. The program centers about children who are entering school for the first time. The pre-school class should not be taken by the reader as a separate program, for it is integrated as a part of total school health.

Sedgwick County, aside from the metropolitan area of Wichita, is typically rural, with a minority of the school districts being located in any incorporated town. The Wichita-Sedgwick County Department of Public Health provides the public health nurses, physicians, dentist and other personnel needed for the health program of the schools in Sedgwick County.

How the Program Developed

The pre-school classes were developed from the school round-up idea. It was felt that school round-ups did not fulfill the needs of the child nor permit a sound and practical participation of the parent. Too many parents said they appreciated the round-up but they wished they could have talked to the doctor or the nurse. Our pre-school classes were designed, therefore, to provide activity for both the parent and the child. The usual school round-up aim of promoting the sound health of the child was expanded in the pre-school classes; and, in addition, activity was provided to promote parental understanding and participation in the school health program.

The Wichita-Sedgwick County Department of Public Health co-sponsors the pre-school classes with a local community group, the school district cooperating. In most cases the Parent-Teacher Association of that school district is the co-sponsor, although in some cases it has been the Farm Bureau or the American Legion Auxiliary. There were 16 such pre-school classes conducted in the Sedgwick County schools during the spring of 1952. The number of classes in any year depends on the interest of the school district

and the sponsoring group, and on the ability of the health department to provide the needed personnel.

The aim of these three groups—the city-council health department, the local community group and the school—is to provide for the 5-year-old a happy and successful adjustment to school. There are other valuable objectives: to acquaint parents with the school health program; to provide immunization and screening examinations for physical handicaps which may deter the progress of the child in his learning; to assist the parent in understanding principles of preventive health for the well child; to help the parents understand their responsibility for regular medical and dental examinations and for positive health teaching.

A month before the pre-school classes get underway, leaders who will be responsible for the community organization are called to an institute by the president of the Sedgwick County Parent-Teacher Association. All community organizations are asked to send two representatives to the institute—one who had participated in the pre-school classes the previous year, and a new person who will be a carry-over to the next year. In that way there is always some leadership with previous experience.

The pre-school institute is designed to help the local people solve problems of organizing the community. A panel composed of a public health nurse, a school principal, the chairman of a local group that sponsored pre-school classes the previous year, and the county P.T.A. president discussed the organization and activity necessary to conduct the classes. There followed a discussion from the floor in which the participants shared ideas and methods used in carrying out the community organization phase of the pre-school classes. Included in the discussions were matters, such as how to contact the parents of children who will be starting school the next fall, publicity, arrangements for physical facilities, hostesses, baby tenders, securing and training volunteers, and transportation teams to assist parents in getting to the pre-school classes. In some cases it was found to be of mutual advantage to the school administrator and the community group to incorporate the annual spring survey along with the classes.

The pre-school institute was held at the health department offices in order that public health nurses would be available to discuss with community representatives the beginning plans for the classes. Early problems needing attention are fixing dates and arranging meetings to train volunteers to weigh, measure, register and fill out school health records.

With the community organization being handled by the co-sponsor, the health department is left only with the responsibility of the actual program content. As stated previously, the program is divided into activity for the children and for the parents. The classes for the parents provide the distinction and, for the community, the real advantage of this program in comparison with the old school round-up experiences. It is the object of the parent's classes to have experts discuss various phases of the health of the pre-schooler, to answer questions, and to be available for personal consultation with the parent.

The Details of the Program

The pre-schoolers are separated from the parents, and baby sitters attend any youngsters the parent may bring in order that the parent may give full attention to the discussion without any interruption.

The classes are divided into three sessions one month apart so as to fit the immunization schedule. In the first session, a physician and a psychologist discuss with the parents the physical and emotional development of the kindergarten-aged child. Because the two subjects are so closely related, the actual presentation is in the form of a panel discussion. Parents are encouraged to obtain for their children complete physical examinations by the family physician before school and regularly thereafter. The audience then gets into the discussion with a free mixture of questions and experiences. The physician and the psychologist remain to answer personal questions of the parent in private conference. The physician also evaluates the immunization history of the child in order to determine what is necessary to give the child proper protection to diphtheria, whooping cough, tetanus and smallpox. In the larger towns where there is a local physician, he often participates in this session also.

The second session has a nutritionist discuss the problems of feeding little folks. This is followed by the local dentist, if one is available, or the public health educator, discussing dental health for the pre-schooler, which includes a demonstration of proper tooth-brushing techniques. This session never fails to produce the kind of questions in which the parent asks, What can I do when my child won't eat a good breakfast? or, How can I get my child into the tooth-brushing habit?

The final session permits a health department sanitarian to discuss accident prevention for the pre-schooler. The significance of accidents as the leading cause of death among school-aged chil-

dren is pointed out. Parents discuss the many ways in which child accidents may be prevented at home and in going to and from school. As a climax to this final session, the public health nurse ties all the various subjects that have been previously discussed into one bundle centered about the individual child. She talks about the school health program, the individual school health record and its value, and finally the responsibility of the parent in joining with the school, community and health department in the school health program. It is the sanitarian and the public health nurse in whose district the school is located that appear on the final program. The sanitarian regularly visits the school on a quarterly basis to provide consultation in problems of the school environment. The nurse is at the school during each week. Parents in this way, then, become acquainted with the personalities who are regularly in their area.

While the parents are in their discussion meetings, the children are being given a series of screening examinations designed to locate physical disabilities which may handicap the child's progress in school. Examination of vision is given by means of the Snellen test. Hearing loss is detected by means of a Maico audiometer. A dentist examines the teeth for defects. Weight and measurements are recorded. Immunizations are given where needed. The individual school health record of the child is begun at the pre-school class. This has been found to have two advantages. It saves much time during the busy beginning of school when health records are normally begun. After some physical defect is found and the parents have been notified that they should have the family physician examine the defect and make corrections if possible or necessary, it permits the summer months to be used as a follow-up period by the parent and the public health nurse in order that the child may be truly ready for school in the fall and thereby be able to make a successful and happy adjustment to school.

Normally, the co-sponsoring group serves light refreshments to the parents and the children at the end of the last session.

Observations and Conclusions

Parents have been enthusiastic about the pre-school classes in Sedgwick County. In many cases where mothers have been working during the daytime at the airplane construction plants in Wichita, the fathers have brought the children to pre-school classes and have participated just as eagerly in the session as the mothers.

The pre-school classes, as herein described, may serve as a guide to other communities in developing a strong, positive program for preparing pre-school children and their parents for the time when the child will start his long experience in school. It is evident that the parent needs this preparation just as much as the child. It is felt by the staff members of the Wichita-Sedgwick County Department of Public Health that parent and child reaction to the school health program depends in so large a part on their beginning experience that more and more emphasis is being placed on a good beginning through the pre-school classes.

Despite three years' experience with these classes, ways are still being found to strengthen and improve the program. In several schools this year, the kindergarten or first grade teacher participated in one session in order to permit her to become acquainted with the children and the parents, and in order to further prepare the child for school. She is able to answer the inevitable questions that arise: Should we teach our youngsters how to count or say their A-B-C's or to read before they start school? In spite of the fact that the teacher is busy, it is thought well to have her in the program. A tour of the school is often appreciated so that, on the beginning school day, everything is not totally strange to the child.

It is now thought advisable to have the sessions closer together and completed before school closes in the spring. Vacations and summer camps and other varied activity following the close of school make it difficult for many parents and children to participate in final sessions. Therefore, it is planned that the Sedgwick County pre-school classes in 1953 will be extended to four sessions, to include the teacher, school administrator and other phases of health; that they will be two weeks apart, making necessary adjustments to complete the immunizations of those children that require a full series of injections; and that the sessions will be completed before school closes in the spring.

* * * * *

MEETING

The annual meeting of the American School Health Association will be held November 9-13, 1953, in New York City, New York. The Hotel New Yorker will serve as headquarters of the Association.

* * * *

Tuberculosis can be prevented and can be cured, yet 2,500 people die of the disease every month in the United States.

THE VALUE OF SEGREGATED CLASSES VERSUS REGULAR CLASSROOM INSTRUCTION FOR POST RHEUMATIC FEVER CHILDREN

Department of Public Health and Preventive Medicine
Stanford University Medical School, San Francisco, California
By RAYMOND G. NEBELUNG, Dr. P.H., Ed.D.

(*Second Installment*)

Growth records afford one of the best methods of determining whether a child is developing normally or otherwise. Wetzel has stated that a child who fails to grow properly is not healthy and should be placed under medical observation (11).

Review of the literature for the past fifteen years reveals a dearth of information on the subsequent effects of rheumatic fever in relation to growth other than the work of Benn in England. In two series of cases, one with a five-year previous onset and having no recurrent attacks during the year prior to the last weighing, and another series with a two-year history of the disease with no recurrences during this period, this investigator found the "children with a history of rheumatic fever are very little, if at all, lighter than normal children; and that rheumatic heart disease probably has no inhibiting effect on the growth of children once the infection has subsided." Therefore, he concluded that neither the type of rheumatic infection nor the presence of cardiac enlargement had any significance relative to growth (12).

Likewise, other workers in reporting the problem of growth in general appear to be less impressed with the effects of recurrent infections as a predominant factor in retardation of growth because it has been noted that severe illnesses frequently leave no evidence a few months after convalescence (13, 14, 15).

Obviously, there are numerous factors that influence the child's physical conditions and the rate of growth. Among these, diet is regarded as being one of the most important, but is is always neces-

11. Wetzel, W. C. Physical Fitness in Terms of Physique, Development and Basal Metabolism with a Guide to Individual Progress from Infancy to Maturity." *Journal of the American Medical Association*, Vol. 116, No. 12, March 22, 1941, pp. 1188.
12. Benn, J. "The Nutritional State of Children with Chronic Disease." *Archives of Diseases of Children*, Vol. 23, October 1948, pp. 174-175.
13. Gray Hill, N., *London County Council Annual Report*, Vol. 4, Part 3, 1933.
14. Evans, M. E., "Illness History and Physical Growth." *American Journal of Diseases of Children*, Vol. 68, December 1944, pp. 390-394.
15. Stewart, M. C., "Need for Observations of Growth in Appraising Adequacy of Nutrition in Childhood," *American Journal Diseases of Children*, Vol. 65, February 1943, p. 320.

sary to eliminate other causes that may be responsible for growth failure.

In attempting to determine what effect, if any, the school situation had exerted on the rate of growth in the children in this study, it is necessary to point out wherein the two types of class routine differ.

Health class cases receive daily a mid-morning and afternoon nutrition period consisting of one-half pint of milk and crackers at each serving, which is also supplemented by cod liver oil. These children eat independently of other students and are supervised by the teacher during this period.

The public health nurses in the schools were charged with the responsibility of weighing and measuring the children. This procedure had a dual advantage in that it provided experienced personnel for collecting the data and made it possible to obtain measurements in all the schools on the same date. Specific instructions were also provided to insure uniformity of measurements. Prior to each weighing, a form letter was addressed to each school principal by the Office of the Board of Education with an attached list containing the names of the pupils and a place for recording the measurements.

This policy made it possible to locate the child for the next weighing in the event that he had transferred to another school during the interim between weighings. Children were weighed with indoor clothing on minus sweaters, shoes, and articles removed from the pockets. Wetzel states that the Grid is applicable to "any method consistenly employed and suitable to the scene of the examination" (16). Obviously the amounts of exercise, meals, water drunk, and other unknown factors must have influenced the values obtained; but all these influences were, to the best of our knowledge, unbiased and presumably did not operate in any one direction to raise or lower the averages. Six measurements were obtained during the course of the study.

The data were then plotted on the Wetzel Grid (17). This instrument was selected because it provides a systematic procedure for evaluating growth, using each child as his own standard, and also because it is a simple objective method whereby the character of the individual growth and development may be readily and clearly observed.

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16. Wetzel, N. C. *Instruction in the Use of the Grid for Evaluating Physical Fitness.* N E. A. Press, p.7.
17. Ibid, same as above.

The number of developmental levels gained (speed of growth) was determined for each child by subtracting the number of levels reached when the initial height and weight were plotted on the Grid from that attained at the time of the last weight. Both types of health class classes were again combined in this analysis because of the similiarity of the data.

Means, Standard Deviations and Critical Ratios were computed from these data for each group. Critical Ratios were done to test the degree of statistical significance between the Means (18). According to Wetzel, the speed of development is at the rate of *one level line a month.* Acceptable deviations allowed from this schedule are 2-3 levels per year (19). "Values greater or less than this are regarded as being unsatisfactory even though development is proceeding strictly at the channel slope (20)."

Both groups in each sample had children that were considerably more or less than the accepted range allowed by this criterion. The regular class in each of the five samples contained cases that not only failed to gain but lost weight, whereas the health class children failed to gain in four out of the five years, and in only one year (1945) had two cases who actually lost weight. Range of growth for the regular group was from a low of 0-15 development levels in 1945 to 0-22 levels in 1946, as compared to a low of 1-12 in 1945 to a high of 0-20 levels in 1948 for the health class. Those cases who exhibited a markedly accelerated rate of growth may be a manifestation of a recovery phase from simple malnutrition or from an illness in which the child has had an aberrant growth pattern, endocrine disturbance or excessive feeding. Wetzel has noted that "the recovery phases in different children are qualitatively alike; the quantitative differences are great or small when the original departures from the channel and schedule are correspondingly great or small," also "that the child in catching up with himself, regularly exceeds the normal rate of 1 level line per month, by several hundred per cent." (21)

Likewise, a smoldering infection, poor hygiene, glandular dysfunction, socio-economic conditions and problems of emotional maladjustment may be the reasons why some of these children did not attain the expected number of growth levels; failed to grow at

18. McNemar, Quinn. *Psychological Statistics.* Formula 27 a. p. 76.
19. Growth Measurement, *A Useful Guide to Health and Disease in Childhood.* Reprinted from *What's New,* September 1946. Published by Abbott Laboratories.
20. Ibid, same as above.
21. Ibid, pp. 42-43.

all; or lost weight. Other workers have stated that "malnutrition is not simply a matter of starvation but is rather the result of many interacting influences among which food, poor management, irregular habits, and repeated infection all play a part (22)." The causes of growth failure in these children need further investigation, particularly from the standpoint of social maladjustment and socio-economic conditions.

The regular class showed a gradual but steady improvement in the number of levels gained throughout all five samples with the exception of one year, 1945. However, only in the last two onset years did they achieve a satisfactory level of growth in terms of the criterion. The health class samples tended to fluctuate in their rate of growth, but only in one onset year (1945) did they fail to attain a satisfactory level of growth. The number of levels gained by these children also exceeded those reached by the regular class in four out of five of the samples. They also gained the most levels in any one year (1946).

Further analysis of the data showed two significant Critical Ratios, both in favor of the health class. The 1944 onset group just reached significance with a CR of 1.95 or P = .05; for the 1946 sample, the CR was 2.66 or a P = ∠.01. Lack of significance between the 1945 samples is attributed to the failure in the number of levels gained in this year by the health class as compared with the previous sample, because the regular class also failed to show any improvement in this year.

Although the health class continued to show a normal rate of growth in the last two samples, the lack of significance in these years is due to the degree of improvement displayed by the regular class, who also for the first time had satisfactory levels of growth in both of these years.

Sigmas for both groups were tested but they lacked significance, therefore it may be noted that the samples came essentially from the same universe.

Despite the fact that there is no clear cut evidence of superiority of one group over the other, it would appear that some children apparently do better in the health class. The factors responsible for the lack of a more positive trend are not revealed by these data.

Scholastic achievement

Intelligence tests were given prior to the achievement testing program to determine if any significant differences exist be-

22. Ibid, p. 38.

tween the two groups in terms of native ability. Two significant Critical Ratios were obtained on the total sample, 3 through 9, in favor of the regular class for the below—90 category: CR = 2.07 (P = ∠.05), and for the Above—110 category: CR = 2.27 (P = ∠.05). There was no difference in the 90-110 classification.

One significant Critical Ratio was shown on the elementary level (3 through 6) for the Below—90 grouping, in favor of the regular class: CR = 2.16 (P = ∠.05). The Above—110 grouping just approached significance with a CR = 1.92, but the classification 90-110, showed no significance.

At the Junior High level there was no significance among the three classifications.

These data show that there are fewer mentally retarded and more gifted children in the regular class sample than in the health classes, in terms of intelligence.

In order to provide an adequate educational program for the rheumatic fever child, it is important to know, in so far as is possible, his academic capacities; also, the extent to which his potentialities are being achieved under present practices. Tests were given to ascertain mental age and total age grade placement in order to find out the degree of scholastic achievement for each child. Measurement and evaluation programs have been practiced for many years in San Francisco, and are regarded as being a functional part of the instruction program. Although it is well known that such tests have their limitations, they nevertheless serve a useful purpose in getting some insight into the quality of the instruction program, the intellectual make-up of the child, and the degree of mental maturity at each successive development level.

Tests used in this evaluation were those which had been previously selected by a school committee on evaluation of tests for use among all children in the school system.

Data were obtained on 369 students, for Grades 3 through 9. Thirty-five of these students were included in the evaluation of the elementary classes because they had been given recent tests prior to their promotion to Junior High School. In some instances it was impossible to obtain complete data because of absenteeism or illness at the time the tests were given, and because of the heavy demands of the daily teaching program. However, based on the number of cases, the data are a representative sample. No comparisons were possible on the High School level because students were given a variety of tests. Only intelligence tests were obtainable in Grades 1 and 2.

The data were first compiled by grades for each category. Due to the spread of cases throughout all grades, it was necessary to combine the grades in the following manner: 3 and 4; 5 and 6; 7,8, and 9, to allow for statistical evaluations.

Comparisons were then made between the two types of classes. Proportions were computed and Critical Ratios were done to test the degree of significance between the classes.

For the total sample, .30 were normal , .52 were retarded and .18 were accelerated in terms of mental growth. In the regular class, .25 were normal, .57 were retarded and .18 accelerated. The health class had .39 normal, .43 retarded, and .18 accelerated. Both the normal and retarded classifications were significant in favor of the health class with a CR = 2.74 and 2.51, respectively: ($P = \angle .10$ and $\angle .05$ respectively). No differences existed in the accelerated group.

Further analysis of the sample by grade levels revealed that retardation becomes more pronounced for both groups in Grades 5 through 9, as compared with those children in the lower grades.

One of the reasons for the overall increase in retardation for both groups at the Junior and Senior High School levels over the elementary grades was undoubtedly the incidence of recurrent attacks of rheumatic fever with subsequent increase in the amount of absenteeism from school due to illness. Although the initial attack may cause the child to be out of school for a considerable period of time, this loss of work can usually be made up through home teaching, or special tutoring. However, recurrent attacks over a period of years usually result in a more restricted regime of living for the child to prevent undue strain which might further exaggerate an already weakened or damaged heart. Consequently, the student is frequently not allowed to carry a full schedule or put forth the extra effort that would be necessary to bring him up to grade so that his retardation increases. Another factor perhaps is that as the child progresses in school the standards become more exacting so that he finds it increasingly difficult to keep up in grade because of the handicap caused by his illness, and especially more so when it is followed by subsequent recurrent attacks. Evidence of this was substantiated in those sections of the study dealing with absenteeism and recurrent attacks.

For the Grades 5 and 6, the normal and retarded classifications were significant in favor of the health classes with CR = 1.96 and 2.61, respectively: ($P = .05$ and $\angle .001$), respectively. The other grade levels lacked significance in all groupings.

Data presented in Grades 3 through 9 indicate that the incidence of rheumatic fever with subsequent recurrences of the disease is a factor in preventing the child from attaining his optimum degree of scholastic achievement.

Despite the fact that the regular class contained more gifted children and fewer mentally retarded children in terms of native ability, it appears from the above data that placement in a health class is more conductive for the child to work at or above his mental ability, than in the regular class environment.

The importance of educational counseling at the secondary school level, together with the need for extended opportunities, cannot be stressed too much in the interest of promoting maximum growth and development.

Summary

The cases were distributed through 92 public schools in San Francisco in grades 1 through 12. The sample included 245 males and 253 females, or 49.2 and 50.8 respectively. Fifty-three per cent of the regular class sample of 345 cases were females compared to 45 per cent for the health classes of 153 cases. Age at onset for the total group ranged from 4 through 17 years, with an average of 8.5 years. Onset age for the regular class was 4 through 17 years with an average of 8.6; that for the health class was 4 through 13 years, with an average of 8.1 years. Fifty-eight per cent of all cases occurred in the age group 5 through 9 years. The same age group was responsible for 55 per cent of the regular class and 69 per cent of the health class children. Frequency of occurrence of rheumatic fever was highest at age 7 for both groups.

Evaluation of intelligence revealed that 36.3 per cent of all cases had intelligence quotients below 90, and 19.5 per cent were above 110. The regular class had 33.0 per cent below 90 and 22.3 per cent above 110, contrasted with 43.9 and 13.0 per cent respectively for the health class.

Analysis of the data on physical growth showed significance in favor of the health class for two onset samples, 1944 and 1946, with CR = 1.96 (P = .05) and CR = 2.66 or (P = ∠.01). No other years showed significance. The health class reached or exceeded the criterion in four out of the five years, and gained the most levels in any one year.

The evaluation of the data on scholastic achievement showed that 30 per cent of the total sample were normal, 52 per cent were

retarded and 18 per cent accelerated. The regular class had 25 per cent normal, 57 per cent retarded and 18 per cent accelerated compared with 39 per cent normal, 43 per cent retarded and 18 per cent accelerated for the health class. Both the normal and retarded classifications showed significance in favor of the health class with CR = 2.74 and 2.51 ($P = \angle .01$ and $\angle .05$ respectively). A difference existed in the accelerated group. Retardation was most pronounced for both groups in grades 5 through 9, compared with those children in the lower grades.

Conclusions

Despite the failure of either group to demonstrate a superior rate of growth in the majority of the years studied, the tendency favored the health class because in only one year did this group fail to reach a satisfactory growth level, whereas in the last two years only did the regular class attain this level.

Rheumatic fever with subsequent remissions was an important factor in causing or leading to retardation in scholastic achievement for both groups. Placement in a health class, however, was more conductive for the child to work at or above his mental ability than in a regular class environment, even though the latter group had more gifted and less mentally retarded children in terms of native ability.

* * * * *

Four Rules For Dental Health.—There are four rules which make up a practical means of providing children with sound dental health. Recently recommended by the American Dental Association as a desirable pattern for all children to follow, the rules are:

A well-balanced diet with consumption of sweets kept to a minimum. Sugar produces the destructive mouth acids and cause dental decay.

Proper toothbrushing habits beginning at an early age. This means brushing the teeth within 10 minutes after eating.

Early detection and care of dental defects. This will prevent larger troubles later. Neglect may produce serious dental problems which will continue throughout life.

Either access to drinking from a community water system containing the proper amount of fluorides for tooth decay prevention, or application of sodium fluoride to the teeth at periodic intervals. Children who drink fluoridated water from birth have from one-half to two-thirds less tooth decay than those who drink fluoride-free water.

PROGRESS REPORT

Committee on School Nursing Policies and Practices

The American School Health Association Committee on School Nursing Policies and Practices functioned last year with Miss Eunice Lamona, Los Angeles, California, as chairman. Committee members were Aria Rosner, Colorado: Stella Kornacki, Connecticut: Madeline Roessler, Illinois: Elsie Rathbun, Kansas: Kay O'Donnell, Missouri: Frances Brewington, Nevada: Annette Eveleth, New Hampshire: Netta Spine, New Jersey: Janet Burns, New Mexico; Josephine McFarland, New York: Mildred Coyle, Pennsylvania: Nell Peterson, South Dakota: Margaret Higgins, Tennessee: C. H. Ray, Texas.

This committee made a survey of nursing practices among nurse members of the organization in 1951 - 1952. The results of the tabulation of these practices were published and distributed at the time of the annual meeting. A wide variation of practices was recorded by this survey, indicating lack of uniformity of duties of school nurses in various part of the country.

Five members of the committee met in Cleveland at the time of the convention, on October 19, 1952. Two meetings open to the membership were held, one on October 19, 1952 at the Hollenden Hotel, the second on October 20, 1952 in the ballroom of the Public Auditorium. At these meetings a statement of basic philosophy and objectives was written and sent to the governing council. The statement follows:

First: The basic philosophy of all school nurses in America today is to aid in the development of each child's highest potential, mental, emotional, physical, social and spiritual growth and to motivate each child to achieve his ultimate goal in adjusting to the good way of life.

Second: The basic objectives of school nursing are:

a. health improvement and health maintenance.
b. concern for the total personality, growth and development of the individual.

The chairman, Miss Lamona, introduced the matter of the preparation of a manual for school nurses which she stated had been requested from nurses. It was decided to prepare a manual, first examining manuals from various parts of the country. The matter of the manual was to be presented to the governing council of the Association.

Although the governing council is very much interested in the preparation of a manual for school nurses, funds are not now available to collect data and to print materials. For this reason, I should like to ask all school nurse members of the American School Health Association to send in suggestions for such a manual. If nurses are working in school systems where manuals are in use, copies of these manuals would be much appreciated by the committee.

Please send any materials which might prove useful in developing a manual to the present chairman, Lyda M. Smiley, 114 Franklin, Redlands, California.

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Any member of the Association who is desirous of serving on a particular committee is urged to contact Dr. Guy N. Magness, President of the Association. Anyone who has been assigned to a committee who is unable to serve should contact Dr. Magness at once. Ed.

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* * * * *

PERSONAL

Wilkins, Walter E.—It is with considerable regret that we inform our readers of the untimely death of Walter E. Wilkins, M.D., former president of The American School Health Association.

Born in Columbia, South Carolina, in July 9, 1903, Dr. Wilkins distinguished himself early in life as a scholar and teacher. He graduated from Vanderbilt University School of Medicine in Nashville, Tennessee in 1938. He taught at his alma mater for several years prior to his graduation. In 1939, he assumed the position of Director of the Division of School Health of the North Carolina State Board of Health remaining in this capacity until 1942 when he became medical nutrition officer, War Food Administration, Washington, D. C. In 1945, he accepted a commission in the United States Public Health Service as Senior Surgeon assuming the post of Director of the Nutrition Section.

He became Director of Nutrition Investigations and Services in the Florida State Board of Health in 1946 conducting extensive surveys and research studies of school children. He is the co-author of a widely-used text on Nutrition as well as the author of numerous articles in his chosen specialty.

Dr. Wilkins was President of The American School Health Association in 1946-47 and remained on the Governing Council thereafter contributing considerable of his time to committee activities. His scholastic ability is attested by his membership in Alpha Omega Alpha. He was also a member of Phi Beta Pi fraternity and numerous scientific and health organizations. An inventor, he perfected the cup needle for taking blood samples for laboratory tests.

A scholar, a true gentleman, an indefatigable worker, Dr. Wilkins brought a wide range of skills to his chosen field. Possessed of remarkable traits of leadership, yet endowed with a deep sense of humility, he truly had qualities of greatness, despite his youth. Those who knew him had a great respect for his abilities. It is with great sorrow that we record his passing. He died March 2 at the age of 49.

E.E.K.

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EDITORIALS

Whither Goes School Health?—As a professional group school health workers may find themselves puzzled at times as to their exact professional status in view of recent trends in the educational field. What, for example, does the future hold for the person contemplating a career in this field? What can he expect?

Despite the remarkable strides that have been made in the more advanced school systems in the development of comprehensive health programs which are commensurate with the needs of children, it is a constant source of chagrin to school health workers in other areas to view with dismay the lethargy manifest by school administrators in their support of school health programs. In these school systems the health worker literally is a "fifth-wheel" in the school organization. His exact status in the school system remains rather nebulous and his future distinctly vague, despite the efforts by state departments of health and education to foster and promote better health programs in these schools.

What about boards of education . . . how many of their members actually comprehend the purpose and content of a school health program? Very few regard it with the same respect, for example, as is accorded the curriculum in mathematics. In rural

areas the stature of the school health program and the esteem in which it is held may be entirely dependent on the contact a board member's family has with members of the health service or health education staff. The number of "shots" administered by the school physician may spell the difference between a satisfactory or unsatisfactory program to a board member. In urban school the activities of school health workers are seldom brought to public attention unless perchance some of their activities come into conflict with ideas held by cultists in the community.

In some communities known to the writer, school health workers are neither "fish nor fowl" — locally speaking; they are not accepted as educators by members of the local teaching profession, and their local medical, dental, and nursing societies fail to recognize them as specialists within the framework of their respective professional organizations.

In some few states the school health worker is recognized by statute. But, in the vast majority of states scant recognition is given his place in school organization.

In only a few states at present does the school health worker find himself recognized by state public health or educational organizations. Sections on school health in these organizations are the exception rather than the rule, despite the preponderance of interest by health workers and teachers in school health problems.

The contributions of the school health worker to the advancement of education and public health are inestimable. Alert school administrators imbued with a modern philosophy of education are quick to recognize these possibilities in the establishment and maintainance of an adequate school health program. Likewise, public health administrators, who believe implicity in the importance of health education, are slowly coming around to the point of view, that the school health worker is an essential part of the total public health program.

The American School Health Association, the American Public Health Association, and the American Association for Health, Physical Education and Recreation and their respective affiliated state societies offer the school health worker tangible evidence of professional security. We must build them ever stronger to the end that greater stability is given this young but growing specialty of public health and education.—*E.E.K.*

Physically Fit for What?—What does the term "physically fit" mean in terms of today's problems of living? In itself, the term is practically meaningless since there is no yardstick to define it, hence the real question is, "Physically fit for what?"

In the last two world holacausts efforts were made on a grandiose scale to make young men physically fit for the hardships of war. Screening measures utilized by the armed forces weeded out large numbers who were "physically unfit" on the basis of physical and mental deficiencies. And what was the result. Thousands of our supposedly physically sound young men were not inducted into service because of failure to measure up to the standards of proficiency laid down by medical authorities in the armed forces. Mass measures at improving their physical fitness, while popular, never did completely satisfy the need for man-power in times of crisis.

Actually, the process of developing and maintaining physical fitness begins in the delivery room of a hospital. The medical care and health supervision given the infant, the pre-school child and the school-age child may determine the difference between physical fitness and the lack of it in young men. For a goodly number, however, no amount of medical care will ever make them physically fit.

In the last war a lot of "pot-bellied medics" learned the meaning of physical fitness programs first-hand—some of them at the expense of their coronary circulation. The army tried its level best to make the protagonists of Aesculapius into agile members of the armed forces. Yet it is doubtful whether it made physically fit specimens out of any of them. But it is a fact, that army physicians developed a wholesome respect for the ability of the infantryman to stand up to the program.

At a time in our history when our very survival depends on our physical fitness, it is urgent, as Rusk[1] points out, that, "What we need is a new yardstick."—*E.E.K.*

Rusk, Howard A.: *Says There is No Norm of Physical Fitness.* Medical Economics, January, 1953; pp. 147-148.

PERSONAL

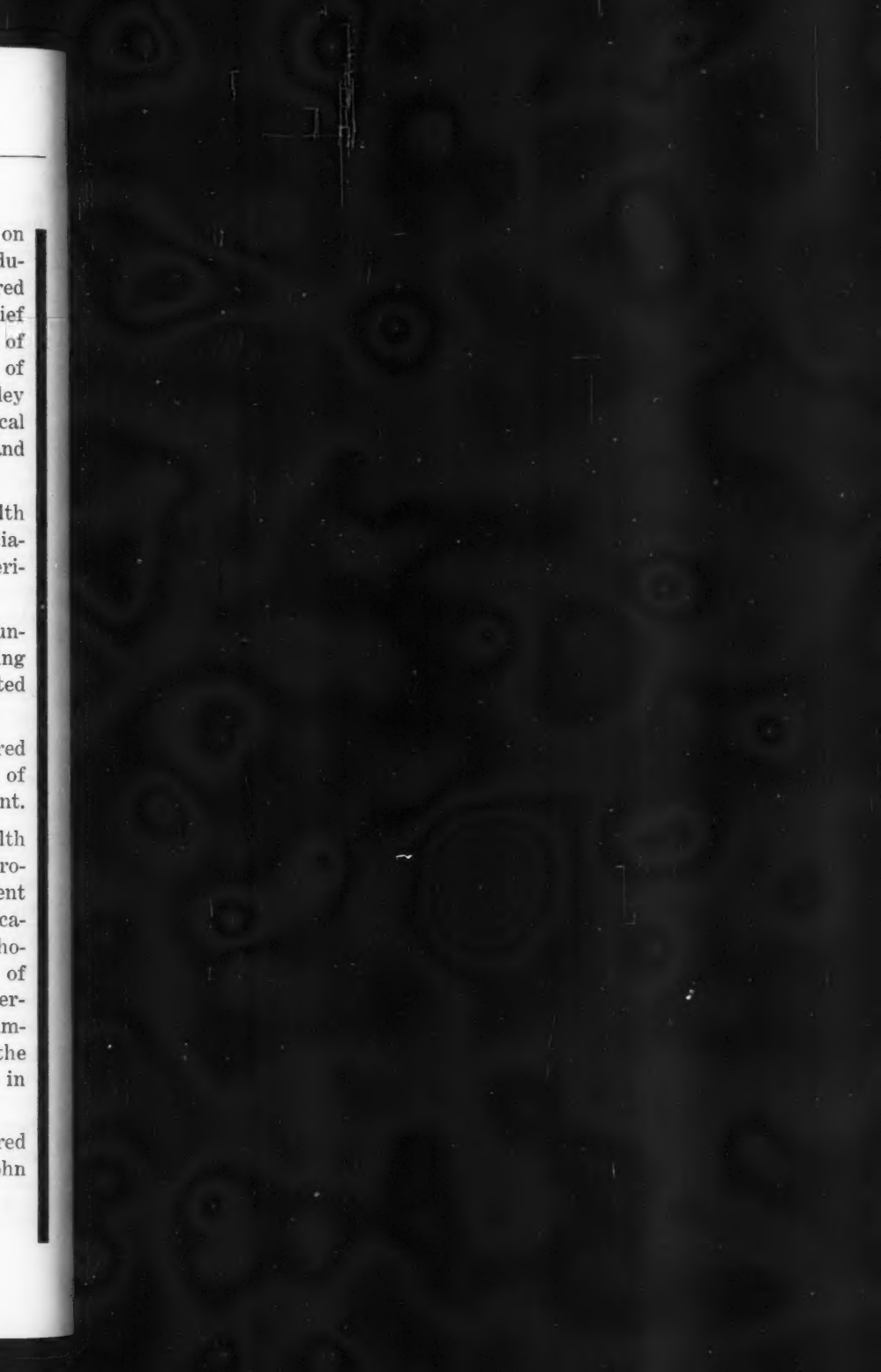
John Edward Burke, M.D., of Schenectady, died on February 11, at the age of sixty-nine. Dr. Burke was graduated from the Albany Medical College in 1915 and had retired in 1949 after thirty-two years as chief school physician, chief medical supervisor and assistant superintendent in charge of health and physical education. Dr. Burke was a member of the American Public Health Association, the Mohawk Valley Neuropsychiatric Society, the Schenectady County Medical Society, the Medical Society of the State of New York, and the American Medical Association.

He was also a member of the American School Health Association and, from its inception, of the American Association of School Physicians, which, in 1936, became the American School Health Association.

From the beginning, Dr. Burke was a leader in the Councils of the Associations, and, in 1931, at the Montreal meeting of the American Association of School Physicians, was elected President for the 1931-1932 term.

He was a veteran of World War I Medical Corps, entered the Medical Corps, Army Reserve and reached the rank of Colonel before his physical condition compelled his retirement.

The position of John Burke was unique in School Health Service. Not only was he director of the School Health Program of the public schools of Schenectady—the Department including Health Services, Health Education, Physical Education, Special Classes for the Handicapped, and the Psychological Testing—but he was Assistant Superintendent of Schools with all the rights, prerogatives and prestige pertaining to that office. Probably, during most of his encumbancy, the School Health Program in Schenectady was the most inclusive and the best organized of that or any city in the United States.

Since we first met, thirty years ago, I had considered myself fortunate in being rated as the close friend of John Edward Burke, pioneer, educator, physician.

Charles H. Keene, M.D.